

## APPENDIX F: CITATIONS TABLE FOR THE DOMAINS OF THE FEM

DOMAIN	CITATIONS
Provider's Performance	<p><b>§ 122C-80. Criminal history record check required for certain applicants for employment.</b></p> <p>(a) Definition. – As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter.</p> <p>(b) Requirement. – An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency.</p> <p>(c) Action. – If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant:</p> <ol style="list-style-type: none"> <li>(1) The level and seriousness of the crime.</li> <li>(2) The date of the crime.</li> <li>(3) The age of the person at the time of the conviction.</li> <li>(4) The circumstances surrounding the commission of the crime, if known.</li> <li>(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.</li> <li>(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.</li> <li>(7) The subsequent commission by the person of a relevant offense.</li> </ol> <p>The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the</p>

<p>Provider's Performance</p>	<p>disqualification, but may not provide a copy of the criminal history record check to the applicant.</p> <p>(d) Limited Immunity. – A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for:</p> <ol style="list-style-type: none"> <li>(1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual.</li> <li>(2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section.</li> </ol> <p>(e) Relevant Offense. – As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.</p> <p>(f) Penalty for Furnishing False Information. – Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.</p> <p>(g) Conditional Employment. – A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met:</p> <ol style="list-style-type: none"> <li>(1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10.</li> <li>(2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.)</li> </ol> <p><b>§ 122C-191. Quality of services.</b></p> <p>(a) The assurance that services provided are of the highest possible quality within available resources is an obligation of the area authority and the Secretary.</p> <p>(b) Each area authority and State facility shall comply with the rules of the Commission regarding quality assurance activities, including: program evaluation; utilization and peer review; and staff qualifications, privileging, supervision, education, and training. These rules may not nullify compliance otherwise required by Chapter 126 of the General Statutes.</p> <p>(c) Each area authority and State facility shall develop internal processes to monitor and evaluate the level of quality obtained by all its programs and services including the activities prescribed in the rules of the Commission.</p> <p>(d) The Secretary shall develop rules for a review process to monitor area facilities and State facilities for compliance with the required quality assurance activities as well as other rules of the Commission and the Secretary. The rules may provide that the Secretary has the authority to determine whether applicable</p>
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<p>Provider's Performance</p>	<p>standards of practice have been met.</p> <p>(e) For purposes of peer review functions only:</p> <ol style="list-style-type: none"> <li>(1) A member of a duly appointed quality assurance committee who acts without malice or fraud shall not be subject to liability for damages in any civil action on account of any act, statement, or proceeding undertaken, made, or performed within the scope of the functions of the committee.</li> <li>(2) The proceedings of a quality assurance committee, the records and materials it produces, and the material it considers shall be confidential and not considered public records within the meaning of G.S. 132-1, " 'Public records' defined," and shall not be subject to discovery or introduction into evidence in any civil action against a facility or a provider of professional health services that results from matters which are the subject of evaluation and review by the committee. No person who was in attendance at a meeting of the committee shall be required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. However, information, documents or records otherwise available are not immune from discovery or use in a civil action merely because they were presented during proceedings of the committee, and nothing herein shall prevent a provider of professional health services from using such otherwise available information, documents or records in connection with an administrative hearing or civil suit relating to the medical staff membership, clinical privileges or employment of the provider. Documents otherwise available as public records within the meaning of G.S. 132-1 do not lose their status as public records merely because they were presented or considered during proceedings of the committee. A member of the committee or a person who testifies before the committee may be subpoenaed and be required to testify in a civil action as to events of which the person has knowledge independent of the peer review process, but cannot be asked about the person's testimony before the committee for impeachment or other purposes or about any opinions formed as a result of the committee hearings.</li> <li>(3) Peer review information that is confidential and is not subject to discovery or use in civil actions under this section may be released to a professional standards review organization that contracts with an agency of this State or the federal government to perform any accreditation or certification function, including the Joint Commission on Accreditation of Healthcare Organizations. Information released under this subdivision shall be limited to that which is reasonably necessary and relevant to the standards review organization's determination to grant or continue accreditation or certification. Information released under this subdivision retains its confidentiality and is not subject to discovery or use in any civil actions as provided under this subsection, and the standards review organization shall keep the information confidential subject to this section. (1977, c. 568, s. 1; 1979, c. 358, s. 1; 1983, c. 383, s. 1; 1985, c. 589, s. 2; 1989 (Reg. Sess., 1990), c. 1053, s. 1; 1998-212, s. 12.35C(d); 1999-222, s. 1; 2004-149, s. 2.7.)</li> </ol> <p><b>10A NCAC 27G .0201 GOVERNING BODY POLICIES</b></p> <p>(a) The governing body responsible for each facility or service shall develop and implement written policies for the following:</p> <ol style="list-style-type: none"> <li>(1) delegation of management authority for the operation of the facility and services;</li> <li>(2) criteria for admission;</li> <li>(3) criteria for discharge;</li> <li>(4) admission assessments, including: <ol style="list-style-type: none"> <li>(A) who will perform the assessment; and</li> <li>(B) time frames for completing assessment.</li> </ol> </li> <li>(5) client record management, including:</li> </ol>
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<p>Provider's Performance</p>	<ul style="list-style-type: none"> <li>(A) persons authorized to document;</li> <li>(B) transporting records;</li> <li>(C) safeguard of records against loss, tampering, defacement or use by unauthorized persons;</li> <li>(D) assurance of record accessibility to authorized users at all times; and</li> <li>(E) assurance of confidentiality of records.</li> </ul> <p>(6) screenings, which shall include:</p> <ul style="list-style-type: none"> <li>(A) an assessment of the individual's presenting problem or need;</li> <li>(B) an assessment of whether or not the facility can provide services to address the individual's needs; and</li> <li>(C) the disposition, including referrals and recommendations;</li> </ul> <p>(7) quality assurance and quality improvement activities, including:</p> <ul style="list-style-type: none"> <li>(A) composition and activities of a quality assurance and quality improvement committee;</li> <li>(B) written quality assurance and quality improvement plan;</li> <li>(C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services;</li> <li>(D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service;</li> <li>(E) strategies for improving client care;</li> <li>(F) review of staff qualifications and a determination made to grant treatment/habilitation privileges;</li> <li>(G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death;</li> <li>(H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;</li> </ul> <p>(8) use of medications by clients in accordance with the rules in this Section;</p> <p>(9) reporting of any incident, unusual occurrence or medication error;</p> <p>(10) voluntary non-compensated work performed by a client;</p> <p>(11) client fee assessment and collection practices;</p> <p>(12) medical preparedness plan to be utilized in a medical emergency;</p> <p>(13) authorization for and follow up of lab tests;</p> <p>(14) transportation, including the accessibility of emergency information for a client;</p> <p>(15) services of volunteers, including supervision and requirements for maintaining client confidentiality;</p> <p>(16) areas in which staff, including nonprofessional staff, receive training and continuing education;</p> <p>(17) safety precautions and requirements for facility areas including special client activity areas; and</p> <p>(18) client grievance policy, including procedures for review and disposition of client grievances.</p> <p>(b) Minutes of the governing body shall be permanently maintained.</p> <p><b>10A NCAC 27G .0202 PERSONNEL REQUIREMENTS</b></p> <p>(a) All facilities shall have a written job description for the director and each staff position which:</p> <ul style="list-style-type: none"> <li>(1) specifies the minimum level of education, competency, work experience and other qualifications for the position;</li> <li>(2) specifies the duties and responsibilities of the position;</li> <li>(3) is signed by the staff member and the supervisor; and</li> </ul>
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<p>Provider's Performance</p>	<p>(4) is retained in the staff member's file.</p> <p>(b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility:</p> <ol style="list-style-type: none"> <li>(1) is at least 18 years of age;</li> <li>(2) is able to read, write, understand and follow directions;</li> <li>(3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and</li> <li>(4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry.</li> </ol> <p>(c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying.</p> <p>(d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided.</p> <p>(e) A file shall be maintained for each individual employee indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification.</p> <p>(f) Continuing education shall be documented.</p> <p>(g) Employee training programs shall be provided and, at a minimum, shall consist of the following:</p> <ol style="list-style-type: none"> <li>(1) general organizational orientation;</li> <li>(2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B;</li> <li>(3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and</li> <li>(4) training in infectious diseases and bloodborne pathogens.</li> </ol> <p>(h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction.</p> <p>(i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.</p> <p><b>10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS</b></p> <p>(a) There shall be no privileging requirements for qualified professionals or associate professionals.</p> <p>(b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served.</p> <p>(c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.</p> <p>(d) Competence shall be demonstrated by exhibiting core skills including:</p> <ol style="list-style-type: none"> <li>(1) technical knowledge;</li> <li>(2) cultural awareness;</li> <li>(3) analytical skills;</li> <li>(4) decision-making;</li> <li>(5) interpersonal skills;</li> <li>(6) communication skills; and</li> <li>(7) clinical skills.</li> </ol> <p>(e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS.</p> <p>(f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional.</p> <p>(g) The associate professional shall be supervised by a qualified professional with the population served for</p>
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<p>Provider's Performance</p>	<p>the period of time as specified in Rule .0104 of this Subchapter.</p> <p><b>10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS</b></p> <p>(a) There shall be no privileging requirements for paraprofessionals.</p> <p>(b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter.</p> <p>(c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served.</p> <p>(d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.</p> <p>(e) Competence shall be demonstrated by exhibiting core skills including:</p> <ol style="list-style-type: none"> <li>(1) technical knowledge;</li> <li>(2) cultural awareness;</li> <li>(3) analytical skills;</li> <li>(4) decision-making;</li> <li>(5) interpersonal skills;</li> <li>(6) communication skills; and</li> <li>(7) clinical skills.</li> </ol> <p>(f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.</p> <p><b>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</b></p> <p>(a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to:</p> <ol style="list-style-type: none"> <li>(1) the client's presenting problem;</li> <li>(2) the client's needs and strengths;</li> <li>(3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission;</li> <li>(4) a pertinent social, family, and medical history; and</li> <li>(5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs.</li> </ol> <p>(b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.</p> <p>(c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days.</p> <p>(d) The plan shall include:</p> <ol style="list-style-type: none"> <li>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;</li> <li>(2) strategies;</li> <li>(3) staff responsible;</li> <li>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;</li> <li>(5) basis for evaluation or assessment of outcome achievement; and</li> <li>(6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.</li> </ol> <p><b>10A NCAC 27G .0206 CLIENT RECORDS</b></p> <p>(a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to:</p> <ol style="list-style-type: none"> <li>(1) an identification face sheet which includes:</li> </ol>
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<p>Provider's Performance</p>	<ul style="list-style-type: none"> <li>(A) name (last, first, middle, maiden);</li> <li>(B) client record number;</li> <li>(C) date of birth;</li> <li>(D) race, gender and marital status;</li> <li>(E) admission date;</li> <li>(F) discharge date;</li> </ul> <ul style="list-style-type: none"> <li>(2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV;</li> <li>(3) documentation of the screening and assessment;</li> <li>(4) treatment/habilitation or service plan;</li> <li>(5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician;</li> <li>(6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician;</li> <li>(7) documentation of services provided;</li> <li>(8) documentation of progress toward outcomes;</li> <li>(9) if applicable: <ul style="list-style-type: none"> <li>(A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM);</li> <li>(B) medication orders;</li> <li>(C) orders and copies of lab tests; and</li> <li>(D) documentation of medication and administration errors and adverse drug reactions.</li> </ul> </li> </ul> <p>(b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143.</p> <p><b>10A NCAC 27G .0504 CLIENT RIGHTS COMMITTEE</b></p> <ul style="list-style-type: none"> <li>(a) The area board shall bear ultimate responsibility for the assurance of client rights.</li> <li>(b) Each area board shall establish at least one Client Rights Committee, and may require that the governing body of a contract agency also establish a Client Rights Committee. The area board shall also develop and implement policy which delineates: <ul style="list-style-type: none"> <li>(1) composition, size, and method of appointment of committee membership;</li> <li>(2) training and orientation of committee members;</li> <li>(3) frequency of meetings, which shall be at least quarterly;</li> <li>(4) rules of conduct for meetings and voting procedures to be followed;</li> <li>(5) procedures for monitoring the effectiveness of existing and proposed methods and procedures for protecting client rights;</li> <li>(6) requirements for routine reports to the area board regarding seclusion, restraint and isolation time out; and</li> <li>(7) other operating procedures.</li> </ul> </li> <li>(c) The area-board-established Client Rights Committee shall oversee, for area-operated services and area-contracted services, implementation of the following client rights protections: <ul style="list-style-type: none"> <li>(1) compliance with G.S. 122C, Article 3;</li> <li>(2) compliance with the provisions of 10A NCAC 27C, 27D, 27E, and 27F governing the protection of client rights, and 10A NCAC 26B governing confidentiality;</li> <li>(3) establishment of a review procedure for any of the following which may be brought by a client, client advocate, parent, legally responsible person, staff or others: <ul style="list-style-type: none"> <li>(A) client grievances;</li> <li>(B) alleged violations of the rights of individuals or groups, including cases of alleged abuse, neglect or exploitation;</li> <li>(C) concerns regarding the use of restrictive procedures; or</li> <li>(D) failure to provide needed services that are available in the area program.</li> </ul> </li> </ul> </li> </ul>
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<p>Provider's Performance</p>	<p>(d) Nothing herein stated shall be interpreted to preclude or usurp the authority of a county Department of Social Services to conduct an investigation of abuse, neglect, or exploitation or the authority of the Governor's Advocacy Council for Persons with Disabilities to conduct investigations regarding alleged violations of client rights.</p> <p>(e) If the area board requires a contract agency to establish a Client Rights Committee, that Committee shall carry out the provisions of this Rule for the contract agency.</p> <p>(f) Each Client Rights Committee shall be composed of a majority of non-area board members, with a reasonable effort made to have all applicable disabilities represented, with consumer and family member representation. Staff who serve on the committee shall not be voting members.</p> <p>(g) The Client Rights Committee shall maintain minutes of its meetings and shall file at least an annual report of its activities with the area board. Clients shall not be identified by name in minutes or in written or oral reports.</p> <p>(h) The area board Client Rights Committee shall review grievances regarding incidents which occur within a contract agency after the governing body of the agency has reviewed the incident and has had opportunity to take action. Incidents of actual or alleged Client Rights violations, the facts of the incident, and the action, if any, made by the contract agency shall be reported to the area director within 30 days of the initial report of the incident, and to the area board within 90 days of the initial report of the incident.</p> <p><b>10A NCAC 27G .0601 SCOPE</b></p> <p>(a) This Section governs Local Management Entity (LME) monitoring of the provision of public services in the LME's catchment area.</p> <p>(b) The LME shall monitor the provision of public services in the LME's catchment area.</p> <p>(c) The LME shall develop and implement written policies governing monitoring of the provision of public services that include:</p> <ol style="list-style-type: none"> <li>(1) receiving, reviewing and responding to level II and level III incident reports as set forth in Rules .0603, .0604, and .0605 of this Section;</li> <li>(2) receiving and responding to complaints concerning the provision of public services, as set forth in Rule .0606 of this Section;</li> <li>(3) conducting local monitoring of Category A and B providers of public services as set forth in Rule .0608 of this Section; and</li> <li>(4) analyzing and reporting trends in the information identified in Subparagraphs (c)(1) through (c)(3) of this Rule, as set forth in Rule .0608 of this Section.</li> </ol> <p>(d) An LME or provider of public services shall exchange information, including confidential information, when necessary to coordinate and carry out the monitoring functions as set forth in this Section. Sharing of information shall conform to 42 CFR, Part 2 for persons receiving Substance Abuse Services. The exchange of information shall apply as follows:</p> <ol style="list-style-type: none"> <li>(1) an LME to another LME;</li> <li>(2) an LME to a provider of public services;</li> <li>(3) a provider of public services to an LME;</li> <li>(4) a provider of public services to another provider of public services;</li> <li>(5) a provider of public services to the Department;</li> <li>(6) an LME to the Department;</li> <li>(7) the Department to an LME; and</li> <li>(8) the Department to a provider of public services.</li> </ol> <p><b>10A NCAC 27G .0602 DEFINITIONS</b></p> <p>In addition to the terms defined in G.S. 122C-3 and Rules .0103 and .0104 of this Subchapter, the following terms shall apply to the rules in this Section:</p> <ol style="list-style-type: none"> <li>(1) "Complaint investigation" means the process of determining if an allegation made against a provider concerning the provision of public services is substantiated.</li> <li>(2) "ICF/MR" means a facility certified for Medicaid as an Intermediate Care Facility for the Mentally Retarded.</li> <li>(3) "Level I incident" means the same as defined in 10A NCAC 27G .0103(b)(32) and does not</li> </ol>
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<p>Provider's Performance</p>	<p>meet the definition of a level II incident or level III incident.</p> <p>(4) "Level II incident" means the same as defined in 10A NCAC 27G .0103(b)(32), including a client death due to natural causes or terminal illness, or results in a threat to a client's health or safety, or a threat to the health or safety of others due to client behavior and does not meet the definition of a level III incident.</p> <p>(5) "Level III incident" means the same as defined in 10A NCAC 27G .0103(b)(32) and results in:</p> <p>(a) a death, sexual assault, or permanent physical or psychological impairment to a client;</p> <p>(b) a substantial risk of death, or permanent physical or psychological impairment to a client;</p> <p>(c) a death, sexual assault, permanent physical or psychological impairment caused by a client;</p> <p>(d) a substantial risk of death or permanent physical or psychological impairment caused by a client; or</p> <p>(e) a threat caused by a client to a person's safety.</p> <p>(6) "Local Monitoring" means LME monitoring of the provision of public services in its catchment area that are provided by Category A and B providers.</p> <p>(7) "Monitor" or "Monitoring" means the interaction between the LME and a provider of public services regarding the functions set forth in Rule .0601(c) of this Section.</p> <p>(8) "Provider category" means the type of facility in which a client receives services or resides. The provider category determines the extent of monitoring that a provider receives and is determined as follows:</p> <p>(a) Category A - facilities licensed pursuant to G.S. 122C, Article 2, except for hospitals. These include 24-hour residential facilities, day treatment, PRTFs and outpatient services;</p> <p>(b) Category B – G.S. 122C, Article 2, community based providers not requiring State licensure;</p> <p>(c) Category C - hospitals, state-operated facilities, nursing homes, adult care homes, family care homes, foster care homes or child care facilities; and</p> <p>(d) Category D - individuals providing only outpatient or day services and who are licensed or certified to practice in the State of North Carolina.</p> <p><b>10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</b></p> <p>(a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by:</p> <p>(1) attending to the health and safety needs of individuals involved in the incident;</p> <p>(2) determining the cause of the incident;</p> <p>(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;</p> <p>(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;</p> <p>(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;</p> <p>(6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and</p> <p>(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.</p> <p>(b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.</p> <p>(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's</p>
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<p>Provider's Performance</p>	<p>premises. The policies shall require the provider to respond by:</p> <ol style="list-style-type: none"> <li>(1) immediately securing the client record by: <ol style="list-style-type: none"> <li>(A) obtaining the client record;</li> <li>(B) making a photocopy;</li> <li>(C) certifying the copy's completeness; and</li> <li>(D) transferring the copy to an internal review team;</li> </ol> </li> <li>(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: <ol style="list-style-type: none"> <li>(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;</li> <li>(B) gather other information needed;</li> <li>(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and</li> <li>(D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and</li> </ol> </li> <li>(3) immediately notifying the following: <ol style="list-style-type: none"> <li>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;</li> <li>(B) the LME where the client resides, if different;</li> <li>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;</li> <li>(D) the Department;</li> <li>(E) the client's legal guardian, as applicable; and</li> <li>(F) any other authorities required by law.</li> </ol> </li> </ol> <p><b>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</b></p> <p>(a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:</p> <ol style="list-style-type: none"> <li>(1) reporting provider contact and identification information;</li> <li>(2) client identification information;</li> <li>(3) type of incident;</li> <li>(4) description of incident;</li> <li>(5) status of the effort to determine the cause of the incident; and</li> <li>(6) other individuals or authorities notified or responding.</li> </ol> <p>(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:</p> <ol style="list-style-type: none"> <li>(1) the provider has reason to believe that information provided in the report may be erroneous,</li> </ol>
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<p>Provider's Performance</p>	<p>misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).</p> <p>(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:</p> <p>(1) medication errors that do not meet the definition of a level II or level III incident;</p> <p>(2) restrictive interventions that do not meet the definition of a level II or level III incident;</p> <p>(3) searches of a client or his living area;</p> <p>(4) seizures of client property or property in the possession of a client;</p> <p>(5) the total number of level II and level III incidents that occurred; and</p> <p>(6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.</p> <p><b>10A NCAC 27G .0606 REFERRAL OF COMPLAINTS TO LOCAL MANAGEMENT ENTITIES PERTAINING TO CATEGORY A OR CATEGORY B PROVIDERS</b></p> <p>(a) The Local Management Entity shall respond to complaints received concerning the provision of public services or client rights pertaining to Category A and B providers within its catchment area.</p> <p>(b) When the Local Management Entity is a subject of the complaint, the LME shall refer the complaint concerning a Category A provider to the Division of Health Service Regulation, or a Category B provider to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services.</p> <p>(c) When the LME receives a complaint concerning a Category A provider, and the complaint is related to a North Carolina rule, the LME shall forward the complaint directly to the Division of Health Service Regulation.</p> <p>(d) When the LME receives a complaint concerning a community-based ICF/MR, the LME shall forward the complaint directly to the Division of Health Service Regulation. The Division of Health Service Regulation is responsible for the complaint investigation.</p> <p>(e) When a complaint investigation involving a Category B provider identifies an issue which if substantiated by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services could result in a revocation or suspension of the provider's funding pursuant to 10A NCAC 26C .0501 through .0504, the LME shall document the issue or issues creating the concern and notify the Division of Mental Health, Developmental Disabilities and Substance Abuse Services of the issue within 24 hours. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services shall consult with the LME, and shall then determine which agency will lead the investigation and which agencies need to be involved. Separate complaint investigations shall not be performed.</p> <p>(f ) When a complaint investigation results in the Local Management Entity initiating action to withdraw endorsement of a provider endorsed by the Local Management Entity, the LME shall follow the requirements identified in 10A NCAC 26C .0709.</p> <p>(g) When facilities employ contract clinical staff to perform clinical functions as a component of the service provided by the provider, the Local Management Entity may investigate a complaint concerning the contracted clinician only if the complaint involves an individual being served in the context of the publicly funded service.</p>
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<p>Provider's Performance</p>	<p><b>10A NCAC 27G .0608 LOCAL MONITORING</b></p> <p>(a) The Local Management Entity shall develop and implement written policies governing local monitoring of Category A and B providers. The written policies shall address:</p> <ol style="list-style-type: none"> <li>(1) the frequency and extent of local monitoring based on the following: <ol style="list-style-type: none"> <li>(A) number and severity of level II or level III incidents reported by the provider;</li> <li>(B) the provider's response to the incidents;</li> <li>(C) the provider's compliance with the reporting requirements as set forth in Rule .0604 of this Section;</li> <li>(D) the number and types of complaints received concerning a provider;</li> <li>(E) the provider's response to the complaints;</li> <li>(F) the conclusions reached from investigation of the complaints;</li> <li>(G) the results of reviews conducted by the Division of Health Service Regulation, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services or the Division of Social Services;</li> <li>(H) compliance with the requirements of the provision of public services;</li> <li>(I) the provider's quality improvement activities as required pursuant to 10A NCAC 27G .0201(7), and trends in improvement;</li> <li>(J) compliance with the contract or Memorandum of Agreement with the Local Management Entity;</li> <li>(K) the addition of a new service; and</li> <li>(L) accreditation by an accreditation agency approved by the Secretary such as the Council on Accreditation (COA), the Council on Quality and Leadership (CQL), the Council on Accreditation of Rehabilitation Facilities (CARF), or The Joint Commission;</li> </ol> </li> <li>(2) The quality of the mental health, developmental disabilities and substance abuse services of all providers;</li> <li>(3) For Category A service providers, the LME shall defer to the Division of Health Service Regulation in the monitoring of any component of services provided which is an element of rule that is monitored by the Division of Health Service Regulation. For Category A providers, the LME shall monitor all components of services provided which are not found in Rule; and</li> <li>(4) If an investigation discloses issues that could affect either the provider's licensure if a Category A provider, or the provider's suspension according to 10A NCAC 26C .0501 through .0504, the Local Management Entity shall refer the provider to either the Division of Health Service Regulation or the Division of Mental Health, Developmental Disabilities and Substance Abuse Services pursuant to Rule .0606 of this Section.</li> </ol> <p>(b) When local monitoring occurs, the Local Management Entity shall communicate the results to the provider within 15 calendar days of completion. The communication of the results shall constitute a local monitoring report that includes:</p> <ol style="list-style-type: none"> <li>(1) identification of each service monitored;</li> <li>(2) identification of any issues requiring correction; and</li> <li>(3) the timelines for implementing the corrections which shall not exceed 60 days from the date the provider receives the local monitoring report.</li> </ol> <p>(c) A Local Management Entity that conducts the local monitoring of a provider serving another Local Management Entity's client shall provide a copy of the local monitoring report to the client's home Local Management Entity within 15 calendar days of completion.</p> <p><b>10A NCAC 27G .0609 LOCAL MANAGEMENT ENTITY REPORTING REQUIREMENTS</b></p> <p>(a) As part of its quality improvement process as set forth in Rule .0201(a)(7) of this Subchapter, the LME shall review, not less than quarterly, patterns and trends in:</p> <ol style="list-style-type: none"> <li>(1) level I, level II and level III incidents;</li> <li>(2) complaints concerning the provision of public services; and</li> <li>(3) local monitoring results gathered pursuant to requirements established in 10A NCAC 27G</li> </ol>
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Provider's Performance	<p>.0608.</p> <p>(b) The LME shall provide reports based on the review specified in Paragraph (a) of this Rule. The reports shall be submitted via electronic means to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services quarterly on forms provided by the Secretary. Copies of the reports shall be provided to the LME's area board, local Consumer and Family Advisory Committee, established by G.S. 122C-170, and the local Client Rights Committee, established by Rule .0504 of this Subchapter.</p> <p>(c) The reports shall include the following:</p> <ol style="list-style-type: none"> <li>(1) summary numbers of the types of complaints, incidents and results of local monitoring;</li> <li>(2) trends identified through analyses of complaints, incidents and local monitoring; and</li> <li>(3) use of the analyses for improvement of the service system and planning of future monitoring activities.</li> </ol> <p><b>10A NCAC 27G .0610 REQUIREMENTS CONCERNING THE NEED FOR PROTECTIVE SERVICES</b></p> <p>(a) If the circumstances identified surrounding an incident, complaint or local monitoring give reasonable cause to believe that a disabled adult receiving services from a Category A or Category B provider may be abused, neglected or exploited and in need of protective services, the Local Management Entity shall ensure the procedures outlined in G.S. 108A, Article 6, are initiated.</p> <p>(b) If the circumstances surrounding an incident, complaint or local monitoring reveal that a child or adolescent may be abused, neglected or exploited and in need of protective services, the Local Management Entity shall ensure the procedures outlined in G.S. 7B, Article 3, are initiated.</p> <p><b><i>Records Management and Documentation Manual [APSM 45-2]</i></b></p>
Status with Other Agencies That Have Oversight Responsibilities	<p><b>§ 122C-80. Criminal history record check required for certain applicants for employment.</b> [See above.]</p> <p><b>§ 122C-191. Quality of services.</b> [See above.]</p> <p><b>10A NCAC 27G .0201 GOVERNING BODY POLICIES</b> [See above.]</p> <p><b>10A NCAC 27G .0601 SCOPE</b> [See above.]</p> <p><b>10A NCAC 27G .0608 LOCAL MONITORING</b> [See above.]</p> <p><b><i>Records Management and Documentation Manual [APSM 45-2]</i></b></p>
Incident Reporting	<p><b>10A NCAC 27G .0504 CLIENT RIGHTS COMMITTEE</b> [See above.]</p> <p><b>10A NCAC 27G .0601 SCOPE</b> [See above.]</p> <p><b>10A NCAC 27G .0602 DEFINITIONS</b> [See above.]</p> <p><b>10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</b> [See above.]</p>

Incident Reporting	<p><b>10A NCAC 27G .0604</b>      <b>INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</b> [See above.]</p> <p><b>10A NCAC 27G .0608</b>      <b>LOCAL MONITORING</b> [See above.]</p> <p><b>10A NCAC 27G .0609</b>      <b>LOCAL MANAGEMENT ENTITY REPORTING REQUIREMENTS</b> [See above.]</p>
Complaints	<p><b>122C <a href="#">ARTICLE 3 - CLIENTS' RIGHTS AND ADVANCE INSTRUCTION</a>. [TOO LENGTHY TO INSERT]</b></p> <p><b>10A NCAC 27C .0101</b>      <b>SCOPE</b>  (a) These Rules, 10A NCAC 27C, 27D, 27E and 27F, set forth procedures governing the protection of client rights in each public or private facility that provides mental health, developmental disabilities and substance abuse services, with the exception of a state-operated facility. In addition to these Rules, the governing body shall comply with the provisions of G.S. 122C, Article 3, regarding client rights.  (b) A facility that is certified by the Centers for Medicare and Medicaid Services (CMS) as an Intermediate Care Facility for the Mentally Retarded (ICF/MR), or a Medicare/Medicaid Hospital or a Psychiatric Residential Treatment Facility (PRTF) is deemed to be in compliance with the rules in Subchapters 27C, 27D, 27E and 27F, with the exception of Rules 27C .0102; 27D .0101; .0303; 27E .0104; .0105; .0108 and .0109.  (c) A facility that is certified as specified in Paragraph (b) of this Rule shall comply with the following:  (1) use of the definition of physical restraint as specified in Rule .0102 Subparagraph (b)(19) of this Section;  (2) documentation requirements as specified in 10A NCAC 27D .0303 and 10A NCAC 27E .0104; .0105; .0108 and .0109;  (3) debriefing requirements as specified in 10A NCAC 27D .0101 and 10A NCAC 27E .0104; and  (4) training requirements as specified in 10A NCAC 27E .0108 and .0109.</p> <p><b>10A NCAC 27D .0101</b>      <b>POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS</b>  (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66.  (b) The governing body shall develop and implement policy to assure that:  (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and  (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications.  (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies:  (1) any restrictive intervention that is prohibited from use within the facility; and  (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client.  (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify:  (1) the permitted restrictive interventions or allowed restrictions;  (2) the individual responsible for informing the client; and  (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions.  (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and</p>

Complaints	<p>implement policy that assures compliance with Subchapter 27E, Section .0100, which includes:</p> <ol style="list-style-type: none"> <li>(1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E);</li> <li>(2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and</li> <li>(3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention.</li> </ol> <p>(f) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policies which require that:</p> <ol style="list-style-type: none"> <li>(1) positive alternatives and less restrictive interventions are considered and are used whenever possible prior to the use of more restrictive interventions; and</li> <li>(2) consideration is given to the client's physical and psychological well-being before, during and after utilization of a restrictive intervention, including: <ol style="list-style-type: none"> <li>(A) review of the client's health history or the comprehensive health assessment conducted upon admission to a facility. The health history or comprehensive health assessment shall include the identification of pre-existing medical conditions or any disabilities and limitations that would place the client at greater risk during the use of restrictive interventions;</li> <li>(B) continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of physical restraint throughout the duration of the restrictive intervention by staff who are physically present and trained in the use of emergency safety interventions;</li> <li>(C) continuous monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being during the use of manual restraint; and</li> <li>(D) continued monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being for a minimum of 30 minutes subsequent to the termination of a restrictive intervention; and</li> </ol> </li> <li>(3) following the utilization of a restrictive intervention, staff shall conduct debriefing and planning with the client and the legally responsible person, if applicable, as specified in 10A NCAC 27E .0104, to eliminate or reduce the probability of the future use of restrictive interventions. Debriefing and planning shall be conducted, as appropriate, to the level of cognitive functioning of the client.</li> </ol> <p><b>10A NCAC 27D .0102      SUSPENSION AND EXPULSION POLICY</b></p> <p>(a) Each client shall be free from threat or fear of unwarranted suspension or expulsion from the facility.</p> <p>(b) The governing body shall develop and implement policy for suspension or expelling a client from a service. The policy shall address the criteria to be used for an suspension, expulsion or other discharge not mutually agreed upon and shall establish documentation requirements that include:</p> <ol style="list-style-type: none"> <li>(1) the specific time and conditions for resuming services following suspension;</li> <li>(2) efforts by staff of the facility to identify an alternative service to meet the client's needs and designation of such service; and</li> <li>(3) the discharge plan, if any.</li> </ol> <p><b>10A NCAC 27D .0103      SEARCH AND SEIZURE POLICY</b></p> <p>(a) Each client shall be free from unwarranted invasion of privacy.</p> <p>(b) The governing body shall develop and implement policy that specifies the conditions under which searches of the client or his living area may occur, and if permitted, the procedures for seizure of the client's belongings, or property in the possession of the client.</p> <p>(c) Every search or seizure shall be documented. Documentation shall include:</p>
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Complaints	<ol style="list-style-type: none"> <li>(1) scope of search;</li> <li>(2) reason for search;</li> <li>(3) procedures followed in the search;</li> <li>(4) a description of any property seized; and</li> <li>(5) an account of the disposition of seized property.</li> </ol> <p><b>10A NCAC 27D .0104 PERIODIC INTERNAL REVIEW</b></p> <p>(a) The governing body shall assure the conduct, no less than every three years, of a compliance review in each of its facilities regarding the implementation of Client Rights Rules as specified in 10A NCAC 27C, 27D, 27E and 27F.</p> <p>(b) The review shall assure that:</p> <ol style="list-style-type: none"> <li>(1) there is compliance with applicable provisions of the federal law governing advocacy services to the mentally ill, as specified in the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (Public Law 99-319) and amended by Public Law 100-509 (1988); and</li> <li>(2) there is compliance with applicable provisions of the federal laws governing advocacy services to the developmentally disabled, the Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. 6000 et. seq.</li> </ol> <p>(c) The governing body shall maintain the three most recent written reports of the findings of such reviews.</p> <p><b>10A NCAC 27D .0201 INFORMING CLIENTS</b></p> <p>(a) A written summary of client rights as specified in G.S. 122C, Article 3 shall be made available to each client and legally responsible person.</p> <p>(b) Each client shall be informed of his right to contact the Governor's Advocacy Council for Persons with Disabilities (GACPD), the statewide agency designated under federal and State law to protect and advocate the rights of persons with disabilities.</p> <p>(c) Each client shall be informed regarding the issues specified in Paragraph (d) and, if applicable in Paragraph (e), of this Rule, upon admission or entry into a service, or</p> <ol style="list-style-type: none"> <li>(1) in a facility where a day/night or periodic service is provided, within three visits; or</li> <li>(2) in a 24-hour facility, within 72 hours. Explanation shall be in a manner consistent with the client's or legally responsible person's level of comprehension.</li> </ol> <p>(d) In each facility, the information provided to the client or legally responsible person shall include;</p> <ol style="list-style-type: none"> <li>(1) the rules that the client is expected to follow and possible penalties for violations of the rules;</li> <li>(2) the client's protections regarding disclosure of confidential information, as delineated in G.S. 122C-52 through G.S. 122C-56;</li> <li>(3) the procedure for obtaining a copy of the client's treatment/habilitation plan; and</li> <li>(4) governing body policy regarding: <ol style="list-style-type: none"> <li>(A) fee assessment and collection practices for treatment/habilitation services;</li> <li>(B) grievance procedures including the individual to contact and a description of the assistance the client will be provided;</li> <li>(C) suspension and expulsion from service; and</li> <li>(D) search and seizure.</li> </ol> </li> </ol> <p>(e) In addition, for the client whose treatment/habilitation is likely to include the use of restrictive interventions, or for the client in a 24-hour facility whose rights as specified in G.S. 122C-62 (b) or (d) may be restricted, the client or legally responsible person shall also be informed:</p> <ol style="list-style-type: none"> <li>(1) of the purposes, goals and reinforcement structure of any behavior management system that is allowed;</li> <li>(2) of potential restrictions or the potential use of restrictive interventions;</li> <li>(3) of notification provisions regarding emergency use of restrictive intervention procedures;</li> <li>(4) that the legally responsible person of a minor or incompetent adult client may request notification after any occurrence of the use of restrictive intervention;</li> <li>(5) that the competent adult client may designate an individual to receive notification, in accordance with G.S. 122C-53(a), after any occurrence of the use of restrictive intervention;</li> </ol>
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Complaints	<p>and (6) of notification provisions regarding the restriction of client rights as specified in G.S. 122C-62(e).</p> <p>(f) There shall be documentation in the client record that client rights have been explained.</p> <p><b>10A NCAC 27D .0202 INFORMING STAFF</b> The governing body shall develop and implement policy to assure that all staff are kept informed of the rights of clients as specified in 122C, Article 3, all applicable rules, and policies of the governing body. Documentation of receipt of information shall be signed by each staff member and maintained by the facility.</p> <p><b>10A NCAC 27D .0301 SOCIAL INTEGRATION</b> Each client in a day/night or 24-hour facility shall be encouraged to participate in appropriate and generally acceptable social interactions and activities with other clients and non-client members of the community. A client shall not be prohibited from such social interactions unless restricted in writing in the client record in accordance with G.S. 122C-62(e).</p> <p><b>10A NCAC 27D .0302 CLIENT SELF-GOVERNANCE</b> In a day/night or 24-hour facility, the governing body shall develop and implement policy which allows client input into facility governance and the development of client self-governance groups.</p> <p><b>10A NCAC 27D .0303 INFORMED CONSENT</b> (a) Each client, or legally responsible person, shall be informed, in a manner that the client or legally responsible person can understand, about:  (1) the alleged benefits, potential risks, and possible alternative methods of treatment/habilitation; and  (2) the length of time for which the consent is valid and the procedures that are to be followed if he chooses to withdraw consent. The length of time for a consent for the planned use of a restrictive intervention shall not exceed six months.  (b) A consent required in accordance with G.S. 122C-57(f) or for planned interventions specified by the rules in Subchapter 27E, Section .0100, shall be obtained in writing. Other procedures requiring written consent shall include, but are not limited to, the prescription or administration of the following drugs:  (1) Antabuse; and  (2) Depo-Provera when used for non-FDA approved uses.  (c) Each voluntary client or legally responsible person has the right to consent or refuse treatment/habilitation in accordance with G.S. 122C-57(d). A voluntary client's refusal of consent shall not be used as the sole grounds for termination or threat of termination of service unless the procedure is the only viable treatment/habilitation option available at the facility.  (d) Documentation of informed consent shall be placed in the client's record.</p> <p><b>10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION</b>  (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66.  (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter.  (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy.  (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter.  (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of</p>
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Complaints	<p>the employee.</p> <p><b>10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE</b></p> <p>(a) Each facility shall provide services/supports that promote a safe and respectful environment. These include:</p> <ol style="list-style-type: none"> <li>(1) using the least restrictive and most appropriate settings and methods;</li> <li>(2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others;</li> <li>(3) providing choices of activities meaningful to the clients served/supported; and</li> <li>(4) sharing of control over decisions with the client/legally responsible person and staff.</li> </ol> <p>(b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include:</p> <ol style="list-style-type: none"> <li>(1) using the intervention as a last resort; and</li> <li>(2) employing the intervention by people trained in its use.</li> </ol> <p><b>10A NCAC 27E .0102 PROHIBITED PROCEDURES</b></p> <p>In each facility the following types of procedures shall be prohibited:</p> <ol style="list-style-type: none"> <li>(1) those interventions which have been prohibited by statute or rule which shall include: <ol style="list-style-type: none"> <li>(a) any intervention which would be considered corporal punishment under G.S. 122C-59;</li> <li>(b) the contingent use of painful body contact;</li> <li>(c) substances administered to induce painful bodily reactions, exclusive of Antabuse;</li> <li>(d) electric shock (excluding medically administered electroconvulsive therapy);</li> <li>(e) insulin shock;</li> <li>(f) unpleasant tasting foodstuffs;</li> <li>(g) contingent application of any noxious substances which include but are not limited to noise, bad smells or splashing with water; and</li> <li>(h) any potentially physically painful procedure, excluding prescribed injections, or stimulus which is administered to the client for the purpose of reducing the frequency or intensity of a behavior.</li> </ol> </li> <li>(2) those interventions determined by the governing body to be unacceptable for or prohibited from use in the facility.</li> </ol> <p><b>10A NCAC 27E .0103 GENERAL POLICIES REGARDING INTERVENTION PROCEDURES</b></p> <p>(a) The following procedures shall only be employed when clinically or medically indicated as a method of therapeutic treatment:</p> <ol style="list-style-type: none"> <li>(1) planned non-attention to specific undesirable behaviors when those behaviors are health threatening;</li> <li>(2) contingent deprivation of any basic necessity; or</li> <li>(3) other professionally acceptable behavior modification procedures that are not prohibited by Rule .0102 of this Section or covered by Rule .0104 of this Section.</li> </ol> <p>(b) The determination that a procedure is clinically or medically indicated, and the authorization for the use of such treatment for a specific client, shall only be made by either a physician or a licensed practicing psychologist who has been formally trained and privileged in the use of the procedure.</p> <p><b>10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL</b></p> <p>(a) This Rule governs the use of restrictive interventions which shall include:</p> <ol style="list-style-type: none"> <li>(1) seclusion;</li> <li>(2) physical restraint;</li> <li>(3) isolation time-out</li> <li>(4) any combination thereof; and</li> </ol>
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Complaints	<p>(5) protective devices used for behavioral control.</p> <p>(b) The use of restrictive interventions shall be limited to:</p> <ol style="list-style-type: none"> <li>(1) emergency situations, in order to terminate a behavior or action in which a client is in imminent danger of abuse or injury to self or other persons or when property damage is occurring that poses imminent risk of danger of injury or harm to self or others; or</li> <li>(2) as a planned measure of therapeutic treatment as specified in Paragraph (f) of this Rule.</li> </ol> <p>(c) Restrictive interventions shall not be employed as a means of coercion, punishment or retaliation by staff or for the convenience of staff or due to inadequacy of staffing. Restrictive interventions shall not be used in a manner that causes harm or abuse.</p> <p>(d) In accordance with Rule .0101 of Subchapter 27D, the governing body shall have policy that delineates the permissible use of restrictive interventions within a facility.</p> <p>(e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions:</p> <ol style="list-style-type: none"> <li>(1) the requirement that positive and less restrictive alternatives are considered and attempted whenever possible prior to the use of more restrictive interventions;</li> <li>(2) consideration is given to the client's physical and psychological well-being before, during and after utilization of a restrictive intervention, including: <ol style="list-style-type: none"> <li>(A) review of the client's health history or the client's comprehensive health assessment conducted upon admission to a facility. The health history or comprehensive health assessment shall include the identification of pre-existing medical conditions or any disabilities and limitations that would place the client at greater risk during the use of restrictive interventions;</li> <li>(B) continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention by staff who are physically present and trained in the use of emergency safety interventions;</li> <li>(C) continuous monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being during the use of manual restraint; and</li> <li>(D) continued monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being for a minimum of 30 minutes subsequent to the termination of a restrictive intervention;</li> </ol> </li> <li>(3) the process for identifying, training, assessing competence of facility employees who may authorize and implement restrictive interventions;</li> <li>(4) the duties and responsibilities of responsible professionals regarding the use of restrictive interventions;</li> <li>(5) the person responsible for documentation when restrictive interventions are used;</li> <li>(6) the person responsible for the notification of others when restrictive interventions are used; and</li> <li>(7) the person responsible for checking the client's physical and psychological well-being and assessing the possible consequences of the use of a restrictive intervention and, in such cases there shall be procedures regarding: <ol style="list-style-type: none"> <li>(A) documentation if a client has a physical disability or has had surgery that would make affected nerves and bones sensitive to injury; and</li> <li>(B) the identification and documentation of alternative emergency procedures, if needed;</li> </ol> </li> <li>(8) any room used for seclusion or isolation time-out shall meet the following criteria: <ol style="list-style-type: none"> <li>(A) the room shall be designed and constructed to ensure the health, safety and well-being of the client;</li> <li>(B) the floor space shall not be less than 50 square feet, with a ceiling height of not less than eight feet;</li> <li>(C) the floor and wall coverings, as well as any contents of the room, shall have a</li> </ol> </li> </ol>
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Complaints	<p>one-hour fire rating and shall not produce toxic fumes if burned;</p> <p>(D) the walls shall be kept completely free of objects;</p> <p>(E) a lighting fixture, equipped with a minimum of a 75 watt bulb, shall be mounted in the ceiling and be screened to prevent tampering by the client;</p> <p>(F) one door of the room shall be equipped with a window mounted in a manner which allows inspection of the entire room;</p> <p>(G) glass in any windows shall be impact resistant and shatterproof;</p> <p>(H) the room temperature and ventilation shall be comparable and compatible with the rest of the facility; and</p> <p>(I) in a lockable room the lock shall be interlocked with the fire alarm system so that the door automatically unlocks when the fire alarm is activated if the room is to be used for seclusion.</p> <p>(9) Whenever a restrictive intervention is utilized, documentation shall be made in the client record to include, at a minimum:</p> <p>(A) notation of the client's physical and psychological well-being;</p> <p>(B) notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior;</p> <p>(C) the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used;</p> <p>(D) a description of the intervention and the date, time and duration of its use;</p> <p>(E) a description of accompanying positive methods of intervention;</p> <p>(F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions;</p> <p>(G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and</p> <p>(H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention.</p> <p>(10) The emergency use of restrictive interventions shall be limited, as follows:</p> <p>(A) a facility employee approved to administer emergency interventions may employ such procedures for up to 15 minutes without further authorization;</p> <p>(B) the continued use of such interventions shall be authorized only by the responsible professional or another qualified professional who is approved to use and to authorize the use of the restrictive intervention based on experience and training;</p> <p>(C) the responsible professional shall meet with and conduct an assessment that includes the physical and psychological well-being of the client and write a continuation authorization as soon as possible after the time of initial employment of the intervention. If the responsible professional or a qualified professional is not immediately available to conduct an assessment of the client, but concurs that the intervention is justified after discussion with the facility employee, continuation of the intervention may be verbally authorized until an on-site assessment of the client can be made;</p> <p>(D) a verbal authorization shall not exceed three hours after the time of initial employment of the intervention; and</p> <p>(E) each written order for seclusion, physical restraint or isolation time-out is limited to four hours for adult clients; two hours for children and adolescent clients ages nine to 17; or one hour for clients under the age of nine. The original order shall only be renewed in accordance with these limits or up to a total of 24 hours.</p>
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Complaints	<p>(11) The following precautions and actions shall be employed whenever a client is in:</p> <ul style="list-style-type: none"> <li>(A) seclusion or physical restraint, including a protective device when used for the purpose or with the intent of controlling unacceptable behavior: periodic observation of the client shall occur at least every 15 minutes, or more often as necessary, to assure the safety of the client, attention shall be paid to the provision of regular meals, bathing and the use of the toilet; and such observation and attention shall be documented in the client record;</li> <li>(B) isolation time-out: there shall be a facility employee in attendance with no other immediate responsibility than to monitor the client who is placed in isolation time-out; there shall be continuous observation and verbal interaction with the client when appropriate; and such observation shall be documented in the client record; and</li> <li>(C) physical restraint and may be subject to injury: a facility employee shall remain present with the client continuously.</li> </ul> <p>(12) The use of a restrictive intervention shall be discontinued immediately at any indication of risk to the client's health or safety or immediately after the client gains behavioral control. If the client is unable to gain behavioral control within the time frame specified in the authorization of the intervention, a new authorization must be obtained.</p> <p>(13) The written approval of the designee of the governing body shall be required when the original order for a restrictive intervention is renewed for up to a total of 24 hours in accordance with the limits specified in Item (E) of Subparagraph (e)(10) of this Rule.</p> <p>(14) Standing orders or PRN orders shall not be used to authorize the use of seclusion, physical restraint or isolation timeout.</p> <p>(15) The use of a restrictive intervention shall be considered a restriction of the client's rights as specified in G.S. 122C-62(b) or (d). The documentation requirements in this Rule shall satisfy the requirements specified in G.S. 122C-62(e) for rights restrictions.</p> <p>(16) When any restrictive intervention is utilized for a client, notification of others shall occur as follows:</p> <ul style="list-style-type: none"> <li>(A) those to be notified as soon as possible but within 24 hours of the next working day, to include: <ul style="list-style-type: none"> <li>(i) the treatment or habilitation team, or its designee, after each use of the intervention; and</li> <li>(ii) a designee of the governing body; and</li> </ul> </li> <li>(B) the legally responsible person of a minor client or an incompetent adult client shall be notified immediately unless she/he has requested not to be notified.</li> </ul> <p>(17) The facility shall conduct reviews and reports on any and all use of restrictive interventions, including:</p> <ul style="list-style-type: none"> <li>(A) a regular review by a designee of the governing body, and review by the Client Rights Committee, in compliance with confidentiality rules as specified in 10A NCAC 28A;</li> <li>(B) an investigation of any unusual or possibly unwarranted patterns of utilization; and</li> <li>(C) documentation of the following shall be maintained on a log: <ul style="list-style-type: none"> <li>(i) name of the client;</li> <li>(ii) name of the responsible professional;</li> <li>(iii) date of each intervention;</li> <li>(iv) time of each intervention;</li> <li>(v) type of intervention;</li> <li>(vi) duration of each intervention;</li> <li>(vii) reason for use of the intervention;</li> <li>(viii) positive and less restrictive alternatives that were used or that were considered but not used and why those alternatives were not used;</li> <li>(ix) debriefing and planning conducted with the client, legally responsible person, if applicable, and staff, as specified in Parts (e)(9)(F) and (G) of this</li> </ul> </li> </ul>
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Complaints	<p>Rule, to eliminate or reduce the probability of the future use of restrictive interventions; and</p> <p>(x) negative effects of the restrictive intervention, if any, on the physical and psychological well-being of the client.</p> <p>(18) The facility shall collect and analyze data on the use of seclusion and physical restraint. The data collected and analyzed shall reflect for each incident:</p> <p>(A) the type of procedure used and the length of time employed;</p> <p>(B) alternatives considered or employed; and</p> <p>(C) the effectiveness of the procedure or alternative employed.</p> <p>The facility shall analyze the data on at least a quarterly basis to monitor effectiveness, determine trends and take corrective action where necessary. The facility shall make the data available to the Secretary upon request.</p> <p>(19) Nothing in this Rule shall be interpreted to prohibit the use of voluntary restrictive interventions at the client's request; however, the procedures in this Rule shall apply with the exception of Subparagraph (f)(3) of this Rule.</p> <p>(f) The restrictive intervention shall be considered a planned intervention and shall be included in the client's treatment/habilitation plan whenever it is used:</p> <p>(1) more than four times, or for more than 40 hours, in a calendar month;</p> <p>(2) in a single episode in which the original order is renewed for up to a total of 24 hours in accordance with the limit specified in Item (E) of Subparagraph (e)(10) of this Rule; or</p> <p>(3) as a measure of therapeutic treatment designed to reduce dangerous, aggressive, self-injurious or undesirable behaviors to a level which will allow the use of less restrictive treatment or habilitation procedures.</p> <p>(g) When a restrictive intervention is used as a planned intervention, facility policy shall specify:</p> <p>(1) the requirement that a consent or approval shall be considered valid for no more than six months and that the decision to continue the specific intervention shall be based on clear and recent behavioral evidence that the intervention is having a positive impact and continues to be needed;</p> <p>(2) prior to the initiation or continued use of any planned intervention, the following written notifications, consents and approvals shall be obtained and documented in the client record:</p> <p>(A) approval of the plan by the responsible professional and the treatment and habilitation team, if applicable, shall be based on an assessment of the client and a review of the documentation required by Subparagraph (e)(9) and (e)(14) of this Rule if applicable;</p> <p>(B) consent of the client or legally responsible person, after participation in treatment planning and after the specific intervention and the reason for it have been explained in accordance with 10A NCAC 27D .0201;</p> <p>(C) notification of an advocate/client rights representative that the specific intervention has been planned for the client and the rationale for utilization of the intervention; and</p> <p>(D) physician approval, after an initial medical examination, when the plan includes a specific intervention with reasonably foreseeable physical consequences. In such cases, periodic planned monitoring by a physician shall be incorporated into the plan.</p> <p>(3) within 30 days of initiation of the use of a planned intervention, the Intervention Advisory Committee established in accordance with Rule .0106 of this Section, by majority vote, may recommend approval or disapproval of the plan or may abstain from making a recommendation;</p> <p>(4) within any time during the use of a planned intervention, if requested, the Intervention Advisory Committee shall be given the opportunity to review the treatment/habilitation plan;</p> <p>(5) if any of the persons or committees specified in Subparagraphs (h)(2) or (h)(3) of this Rule do not approve the initial use or continued use of a planned intervention, the intervention shall</p>
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Complaints	<p>not be initiated or continued. Appeals regarding the resolution of any disagreement over the use of the planned intervention shall be handled in accordance with governing body policy; and</p> <p>(6) documentation in the client record regarding the use of a planned intervention shall indicate:</p> <p>(A) description and frequency of debriefing with the client, legally responsible person, if applicable, and staff if determined to be clinically necessary. Debriefing shall be conducted as to the level of cognitive functioning of the client;</p> <p>(B) bi-monthly evaluation of the planned by the responsible professional who approved the planned intervention; and</p> <p>(C) review, at least monthly, by the treatment/habilitation team that approved the planned intervention.</p> <p><b>10A NCAC 27E .0105 PROTECTIVE DEVICES</b></p> <p>(a) Whenever a protective device is utilized for a client, the governing body shall develop and implement policy to ensure that:</p> <p>(1) the necessity for the protective device has been assessed and the device is applied by a facility employee who has been trained and has demonstrated competence in the utilization of protective devices;</p> <p>(2) the use of positive and less restrictive alternatives have been reviewed and documented and the protective device selected is the appropriate measure;</p> <p>(3) the client is frequently observed and provided opportunities for toileting, exercise, etc. as needed. When a protective device limits the client's freedom of movement, the client shall be observed at least every hour. Whenever the client is restrained and subject to injury by another client, a facility employee shall remain present with the client continuously. Observations and interventions shall be documented in the client record;</p> <p>(4) protective devices are cleaned at regular intervals; and</p> <p>(5) for facilities operated by or under contract with an area program, the utilization of protective devices in the treatment/habilitation plan shall be subject to review by the Client Rights Committee, as required in 10A NCAC 27G .0504. Copies of this Rule and other pertinent rules are published as Division publication RULES FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES, APSM 30-1, and may be purchased at a cost of five dollars and seventy-five cents (\$5.75) per copy.</p> <p>(b) The use of any protective device for the purpose or with the intent of controlling unacceptable behavior shall comply with the requirements of Rule .0104 of this Section.</p> <p><b>10A NCAC 27E .0106 INTERVENTION ADVISORY COMMITTEES</b></p> <p>(a) An Intervention Advisory Committee shall be established to provide additional safeguards in a facility that utilizes restrictive interventions as planned interventions as specified in Rule .0104(g) of this Section.</p> <p>(b) The membership of the Intervention Advisory Committee shall include at least one person who is or has been a consumer of direct services provided by the governing body or who is a close relative of a consumer and:</p> <p>(1) for a facility operated by an area program, the Intervention Advisory Committee shall be the Client Rights Committee or a subcommittee of it, which may include other members;</p> <p>(2) for a facility that is not operated by an area program, but for which a voluntary client rights or human rights committee has been appointed by the governing body, the Intervention Advisory Committee shall be that committee or a subcommittee of it, which may include other members; or</p> <p>(3) for a facility that does not meet the conditions of Subparagraph (b)(1) or (2), the committee shall include at least three citizens who are not employees of, or members of the governing body.</p> <p>(c) The Intervention Advisory Committee specified in Subparagraphs (b)(2) or (3) shall have a member or a regular independent consultant who is a professional with training and expertise in the use of the type of</p>
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Complaints	<p>interventions being utilized, and who is not directly involved in the treatment or habilitation of the client.</p> <p>(d) The Intervention Advisory Committee shall:</p> <ol style="list-style-type: none"> <li>(1) have policy that governs its operation and requirements that: <ol style="list-style-type: none"> <li>(A) access to client information shall be given only when necessary for committee members to perform their duties;</li> <li>(B) committee members shall have access to client records on a need to know basis only upon the written consent of the client or his legally responsible person as specified in G.S. 122C-53(a); and</li> <li>(C) information in the client record shall be treated as confidential information in accordance with G.S. 122C-52 through 122C-56;</li> </ol> </li> <li>(2) receive specific training and orientation as to the charge of the committee;</li> <li>(3) be provided with copies of appropriate statutes and rules governing client rights and related issues;</li> <li>(4) be provided, when available, with copies of literature about the use of a proposed intervention and any alternatives;</li> <li>(5) maintain minutes of each meeting; and</li> <li>(6) make an annual written report to the governing body on the activities of the committee.</li> </ol> <p><b>10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS</b></p> <p>(a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions.</p> <p>(b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented.</p> <p>(c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered.</p> <p>(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.</p> <p>(e) Formal refresher training must be completed by each service provider periodically (minimum annually).</p> <p>(f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.</p> <p>(g) Staff shall demonstrate competence in the following core areas:</p> <ol style="list-style-type: none"> <li>(1) knowledge and understanding of the people being served;</li> <li>(2) recognizing and interpreting human behavior;</li> <li>(3) recognizing the effect of internal and external stressors that may affect people with disabilities;</li> <li>(4) strategies for building positive relationships with persons with disabilities;</li> <li>(5) recognizing cultural, environmental and organizational factors that may affect people with disabilities;</li> <li>(6) recognizing the importance of and assisting in the person's involvement in making decisions about their life;</li> <li>(7) skills in assessing individual risk for escalating behavior;</li> <li>(8) communication strategies for defusing and de-escalating potentially dangerous behavior; and</li> <li>(9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).</li> </ol> <p>(h) Service providers shall maintain documentation of initial and refresher training for at least three years.</p> <ol style="list-style-type: none"> <li>(1) Documentation shall include: <ol style="list-style-type: none"> <li>(A) who participated in the training and the outcomes (pass/fail);</li> <li>(B) when and where they attended; and</li> <li>(C) instructor's name;</li> </ol> </li> </ol>
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Complaints	<p>(2) The Division of MH/DD/SAS may review/request this documentation at any time.</p> <p>(i) Instructor Qualifications and Training Requirements:</p> <p>(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.</p> <p>(2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.</p> <p>(3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.</p> <p>(4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule.</p> <p>(5) Acceptable instructor training programs shall include but are not limited to presentation of:</p> <p>(A) understanding the adult learner;</p> <p>(B) methods for teaching content of the course;</p> <p>(C) methods for evaluating trainee performance; and</p> <p>(D) documentation procedures.</p> <p>(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.</p> <p>(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.</p> <p>(8) Trainers shall complete a refresher instructor training at least every two years.</p> <p>(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.</p> <p>(1) Documentation shall include:</p> <p>(A) who participated in the training and the outcomes (pass/fail);</p> <p>(B) when and where attended; and</p> <p>(C) instructor's name.</p> <p>(2) The Division of MH/DD/SAS may request and review this documentation any time.</p> <p>(k) Qualifications of Coaches:</p> <p>(1) Coaches shall meet all preparation requirements as a trainer.</p> <p>(2) Coaches shall teach at least three times the course which is being coached.</p> <p>(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.</p> <p>(l) Documentation shall be the same preparation as for trainers.</p> <p><b>10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT</b></p> <p>(a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually.</p> <p>(b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated.</p> <p>(c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions.</p> <p>(d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.</p> <p>(e) Formal refresher training must be completed by each service provider periodically (minimum annually).</p>
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Complaints	<p>(f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.</p> <p>(g) Acceptable training programs shall include, but are not limited to, presentation of:</p> <ol style="list-style-type: none"> <li>(1) refresher information on alternatives to the use of restrictive interventions;</li> <li>(2) guidelines on when to intervene (understanding imminent danger to self and others);</li> <li>(3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention);</li> <li>(4) strategies for the safe implementation of restrictive interventions;</li> <li>(5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention;</li> <li>(6) prohibited procedures;</li> <li>(7) debriefing strategies, including their importance and purpose; and</li> <li>(8) documentation methods/procedures.</li> </ol> <p>(h) Service providers shall maintain documentation of initial and refresher training for at least three years.</p> <ol style="list-style-type: none"> <li>(1) Documentation shall include: <ol style="list-style-type: none"> <li>(A) who participated in the training and the outcomes (pass/fail);</li> <li>(B) when and where they attended; and</li> <li>(C) instructor's name.</li> </ol> </li> <li>(2) The Division of MH/DD/SAS may review/request this documentation at any time.</li> </ol> <p>(i) Instructor Qualification and Training Requirements:</p> <ol style="list-style-type: none"> <li>(1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions.</li> <li>(2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out.</li> <li>(3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.</li> <li>(4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.</li> <li>(5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule.</li> <li>(6) Acceptable instructor training programs shall include, but not be limited to, presentation of: <ol style="list-style-type: none"> <li>(A) understanding the adult learner;</li> <li>(B) methods for teaching content of the course;</li> <li>(C) evaluation of trainee performance; and</li> <li>(D) documentation procedures.</li> </ol> </li> <li>(7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule.</li> <li>(8) Trainers shall be currently trained in CPR.</li> <li>(9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach.</li> <li>(10) Trainers shall teach a program on the use of restrictive interventions at least once annually.</li> <li>(11) Trainers shall complete a refresher instructor training at least every two years.</li> </ol> <p>(k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.</p> <ol style="list-style-type: none"> <li>(1) Documentation shall include: <ol style="list-style-type: none"> <li>(A) who participated in the training and the outcome (pass/fail);</li> <li>(B) when and where they attended; and</li> <li>(C) instructor's name.</li> </ol> </li> <li>(2) The Division of MH/DD/SAS may review/request this documentation at any time.</li> </ol>
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Complaints	<p>(l) Qualifications of Coaches:</p> <ol style="list-style-type: none"> <li>(1) Coaches shall meet all preparation requirements as a trainer.</li> <li>(2) Coaches shall teach at least three times, the course which is being coached.</li> <li>(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.</li> </ol> <p>(m) Documentation shall be the same preparation as for trainers.</p> <p><b>10A NCAC 27E .0201 SAFEGUARDS REGARDING MEDICATIONS</b></p> <p>(a) The use of experimental drugs or medication shall be considered research and shall be governed by G.S. 122C-57(f), applicable federal law, licensure requirements codified in 10A NCAC 27G .0209, or any other applicable licensure requirements not inconsistent with state or federal law.</p> <p>(b) The use of other drugs or medications as a treatment measure shall be governed by G.S. 122C-57, and G.S. 90, Articles 1, 4A and 9A.</p> <p><b>10A NCAC 27F .0101 SCOPE</b></p> <p>Article 3, Chapter 122C of the General Statutes provides specific rights for each client who receives a mental health, developmental disability, or substance abuse service. This Subchapter delineates the rules regarding those rights that apply in a 24-hour facility.</p> <p><b>10A NCAC 27F .0102 LIVING ENVIRONMENT</b></p> <p>(a) Each client shall be provided:</p> <ol style="list-style-type: none"> <li>(1) an atmosphere conducive to uninterrupted sleep during scheduled sleeping hours, consistent with the types of services being provided and the type of clients being served; and</li> <li>(2) accessible areas for personal privacy, for at least limited periods of time, unless determined inappropriate by the treatment or habilitation team.</li> </ol> <p>(b) Each client shall be free to suitably decorate his room, or his portion of a multi-resident room, with respect to choice, normalization principles, and with respect for the physical structure. Any restrictions on this freedom shall be carried out in accordance with governing body policy.</p> <p><b>10A NCAC 27F .0103 HEALTH, HYGIENE AND GROOMING</b></p> <p>(a) Each client shall be assured the right to dignity, privacy and humane care in the provision of personal health, hygiene and grooming care. Such rights shall include, but need not be limited to the:</p> <ol style="list-style-type: none"> <li>(1) opportunity for a shower or tub bath daily, or more often as needed;</li> <li>(2) opportunity to shave at least daily;</li> <li>(3) opportunity to obtain the services of a barber or a beautician; and</li> <li>(4) provision of linens and towels, toilet paper and soap for each client and other individual personal hygiene articles for each indigent client. Such other articles include but are not limited to toothpaste, toothbrush, sanitary napkins, tampons, shaving cream and shaving utensil.</li> </ol> <p>(b) Bathtubs or showers and toilets which ensure individual privacy shall be available.</p> <p>(c) Adequate toilets, lavatory and bath facilities equipped for use by a client with a mobility impairment shall be available.</p> <p><b>10A NCAC 27F .0104 STORAGE AND PROTECTION OF CLOTHING AND POSSESSIONS</b></p> <p>Facility employees shall make every effort to protect each client's personal clothing and possessions from theft, damage, destruction, loss, and misplacement. This includes, but is not limited to, assisting the client in developing and maintaining an inventory of clothing and personal possessions if the client or legally responsible person desires.</p> <p><b>10A NCAC 27F .0105 CLIENT'S PERSONAL FUNDS</b></p> <p>(a) This Rule applies to any 24-hour facility which typically provides residential services to individual clients for more than 30 days.</p>
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Complaints	<p>(b) Each competent adult client and each minor above the age of 16 shall be assisted and encouraged to maintain or invest his money in a personal fund account other than at the facility. This shall include, but need not be limited to, investment of funds in interest-bearing accounts.</p> <p>(c) If funds are managed for a client by a facility employee, management of the funds shall occur in accordance with policy and procedures that:</p> <ol style="list-style-type: none"> <li>(1) assure to the client the right to deposit and withdraw money;</li> <li>(2) regulate the receipt and distribution of funds in a personal fund account;</li> <li>(3) provide for the receipt of deposits made by friends, relatives or others;</li> <li>(4) provide for the keeping of adequate financial records on all transactions affecting funds on deposit in personal fund account;</li> <li>(5) assure that a client's personal funds will be kept separate from any operating funds of the facility;</li> <li>(6) provide for the deduction from a personal fund account payment for treatment or habilitation services when authorized by the client or legally responsible person upon or subsequent to admission of the client;</li> <li>(7) provide for the issuance of receipts to persons depositing or withdrawing funds; and</li> <li>(8) provide the client with a quarterly accounting of his personal fund account.</li> </ol> <p>(d) Authorization by the client or legally responsible person is required before a deduction can be made from a personal fund account for any amount owed or alleged to be owed for damages done or alleged to have been done by the client:</p> <ol style="list-style-type: none"> <li>(1) to the facility;</li> <li>(2) an employee of the facility;</li> <li>(3) to a visitor of the facility; or</li> <li>(4) to another client of the facility.</li> </ol> <p><b>10A NCAC 27G .0504      CLIENT RIGHTS COMMITTEE</b> [See above.]</p> <p><b>10A NCAC 27G .0601      SCOPE</b> [See above.]</p> <p><b>10A NCAC 27G .0602      DEFINITIONS</b> [See above.]</p> <p><b>10A NCAC 27G .0606      REFERRAL OF COMPLAINTS TO LOCAL MANAGEMENT ENTITIES PERTAINING TO CATEGORY A OR CATEGORY B PROVIDERS</b> [See above.]</p> <p><b>10A NCAC 27G .0608      LOCAL MONITORING</b> [See above.]</p> <p><b>10A NCAC 27G .0609      LOCAL MANAGEMENT ENTITY REPORTING REQUIREMENTS</b> [See above.]</p> <p><b>10A NCAC 27G .0610      REQUIREMENTS CONCERNING THE NEED FOR PROTECTIVE SERVICES</b> [See above.]</p>
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